MDR Tracking Number: M5-04-1068-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 04-01-03.

The IRO reviewed radiologic exam –whole procedure, neuromuscular re-education, office visits with manipulation, required report, work related exam rendered from 04-02-02 through 06-17-02 that were denied based "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 02-09-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
4-22-02	99213-MP	$48.00 (1 unit)	$0.00	R	$48.00	96 MFG E/M GR (VI)(B)	R – No TWCC-21 on file MDR will review per 96 MFG. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $48.00
4-22-02	97112	$35.00	$0.00	R	$35.00	96 MFG MEDICINE GR (I)(9)(b)	R – No TWCC-21 on file MDR will review per 96 MFG. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $35.00
TOTAL		$83.00	$0.00				Requestor is entitled to reimbursement in the amount of $83.00

This Decision is hereby issued this 13th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 04-02-02 through 06-17-02 in this dispute.

This Order is hereby issued this 13th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

February 5, 2004

MDR #: M5-04-1068-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

REVIEWER'S REVIEW

Information Provided for Review:
Correspondence
H&P and office notes
Physical Therapy notes
Radiology reports

Clinical History:
This male patient received manipulation and physical medicine procedures for a low back injury that occurred on ___, while on his job.

Disputed Services:
Radiologic exam-whole procedure, neuromuscular re-education, office visit with manipulation, required report, work-related exam during the period of 04/02/02 through 06/17/02 (with the exception of dates 04/09/02, 04/15/02, 04/22/02, 04/29/02, 05/06/02, 05/08/02, and 05/13/02).

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatments and services in dispute as stated above were medically necessary in this case.

Rationale:
Without question, the doctor's examination and medical reports fully document the medical necessity of the care rendered. Moreover, the medical records document that the physician's treatment fully complied with the statutes since it

relieved the effects naturally resulting from the compensable injury, promoted recovery and enhanced the ability of the employee to return to or retain employment.

Sincerely,